

AGING AND DISABILITY SERVICES ADMINISTRATION OMNIBUS BUDGET RECONCILIATION ACT (OBRA) NURSING ASSISTANT TRAINING PROGRAM PO BOX 45600 OLYMPIA WA 98504-5600

APPLICATION FOR OBRA PROGRAM RENEWAL (NATCEP)

DATE OF APPLICATION

LEGAL NAME OF SPONSORING HEALTH CARE FACILITY, HOSPITAL, SCHOOL OR OTHER ENTITY			TELEPHONE NUMBER (INCLUDE AREA CODE)				
MAILING ADDRESS	CITY	COL	JNTY	STATE	ZIP CODE		
STREET ADDRESS IF DIFFERENT FROM MAILING ADDRESS	CITY	STATE	ZIP CODE	E-MAIL ADDRES	SS		
NAME OF FACILITY ADMINISTRATOR, VOCATIONAL DIRECTOR	, DEPARTMENT HEAD	OR CHIEF ADMI	INISTRATIVE OFF	ICER			
NAME OF PROGRAM DIRECTOR, NURSING ASSISTANT TRAINING PROGRAM CONTACT TELEPHONE NUMBER					NCLUDE AR	EA CODE)	
If facility was approved for Nursing Assistant Training pre	viously, what is our t	raining progran	n approval numb	er?			
LIST ALL CURRENT INSTRUCTORS							
LIST ALL FACILITIES WHERE CLINICAL TRAINING IS CONDUCT	TED THROUGH YOUR	TRAINING PROG	GRAM:				
Have you reviewed your original application and any add	dendums and renewa	al applications,	if applicable?		Yes	No	
Are there changes in the overall curriculum plan or major curriculum content changes? If yes, please explain. (Attach curriculum changes)							
Has the Program Director changed? (If yes, please complete an application for program director)							
Have the instructors changed? (If yes, please complete an application for each new instructor)							
Has the location, training equipment and/or teaching resources changed? (Do not include updated textbooks)							
If yes, please explain:							
Please complete the Curriculum verification	n forms for OBR	A and subm	nit with this f	orm.			

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The following attachments are required for all programs. Attach the following to this application.					
Application for OBRA Program Director, DSHS 14-370.					
2. Instructional Staff Application(s), DSHS 14-369. This is not applicable if the Program Director is the sole instructor.					
3. The curriculum outline and schedule of class and clinical presentations. The applicant must provide evidence of content that will lead to the achievement of all required nursing assistant competencies listed in CRF 42 483-152.					
representing					
Name of signing party (print) Name of applying entity					
ereby acknowledge my understanding that the renewal process for a nursing assistant training program					
equires approval by the Department of Social and Health Services, before classes can be offered.					
further understand that I must notify the Department of Social and Health Services whenever significant					
changes for the training program occur in personnel, classroom locations, etc.					
Signature Date					